Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2811HIC	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C W HOME CARE	1664 DEEP SPRING AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure survey conducted in your facility on 05/29/09. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The census at the time of the survey was two. Two (2) resident file and zero (0) employee files were reviewed. The following deficiencies were identified:	H 000	7/14/09 P.O.C accepted j.p. H019	
H 019	Director Duties-No FA/CPR NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present. This Regulation is not met as evidenced by: Based on record review and staff interview on 05/29/09 the facility failed to ensure that 1 of	H 019	a.) The Deficiency was Met but the CPR Cards were not Located (See Attachment #1,2.) b.) We have Created Files for Staff and have placed All Required Copies of Certificates, etc. For easy Reference in the Future.	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director — (X6) DATE: 7/10/09

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2811HIC	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C W HOME CARE	1664 DEEP SPRING AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 019	Continued From page 1 1caregiver had received training in cardiopulmonary resuscitation (CPR) and first aid. Findings include: There were no available files to review for Employee #1 and the Administrator of the facility, Employee #2.	H 019	H019 (Cont.) b.) (Cont.) The Director will be Responsible for Reviewing These Files AND Procedure. c.) 6/15/09	
H 033	Safety&Sanitation-First Aid Kit NAC 449.15525 Requirements for safety and sanitation of facility. (NRS 449.249) 2. A home must contain: (c) A first-aid kit; This Regulation is not met as evidenced by: Based on observation on 05/29/09, the facility failed to ensure a first aid kit was available in the home. Finding include: The facility failed to produce a first aid kit upon request. Employee #1 stated "I don't have one here in the home."	H 033	H033 a.) We have purchased A New First Aid Kit AND it is Now Available AT the Home. B) We will Monitor More Closely Materials AND Items For purchase That Are Required. Ms. . will be Responsible For Seeing The Supplies Are well Stocked. c.) 6/15/09	
H 044	Records of Residents-Copy of physical NAC 449.15527 Agreement between operator of home and resident concerning rates; maintenance of records of residents. (NRS 449.249) The operator of a home shall: 2. Maintain a separate, organized file for each resident of the home and retain the file for 5	H 044		

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2811HIC	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C W HOME CARE	1664 DEEP SPRING AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 044	Continued From page 2 years after the resident permanently leaves the home. Each file must include: (c) A copy of the results of a general physical examination of the resident conducted by his physician; and This Regulation is not met as evidenced by: Based on record review on 05/29/09 the facility failed to obtain a current copy of a general physical examination conducted by a physican on 2 of 2 residents (Resident #1 and #2). Findings include: The files of Residents #1 and #2 failed to contain a current general physical examination conducted by the resident's physician.	H 044	H044 A) Resident #1 has Recd An Exam and is Awaiting Form from Doctor. Resident #2 is Scheduled for Aug. 10th and will have the Attached Form Completed (See Attachment #3). B) 6 Month Reviews will be Conducted in the Future To Verify Compliance with this Requirement. The Director will be Responsible for Monitoring This Requirement. C) 8/10/09	
H 045	Records of Residents-Current Needs Assessment NAC 449.15527 Agreement between operator of home and resident concerning rates; maintenance of records of residents. (NRS 449.249) The operator of a home shall: 2. Maintain a separate, organized file for each resident of the home and retain the file for 5 years after the resident permanently leaves the home. Each file must include: (d) A current copy of the assessment of the needs of the resident conducted pursuant to NAC 449.15523.	H 045		

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2811HIC	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C W HOME CARE	1664 DEEP SPRING AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 045	Continued From page 3 This Regulation is not met as evidenced by: Based on record review on 05/29/09, the facility failed to ensure that the needs of each resident was assessed upon admission to the home, and that the assessment was updated as the needs of the resident changed for 2 of 2 residents, (Resident #1 and #2). Findings include: The files of Resident #1 and #2 failed to contain a current copy of the Assessment of the Needs of the Resident conducted pursuant to NAC449.15523.	H 045	H045 A.) We have updated Assessments and faxed under seperate cover Copies of Resident #1 & 2 on 6/26. B.) During our 6 Mo. Review of Resident Files, we will update any changes that may occur. If changes in needs for Assistance should be necessary before the 6 Mo. Review, these will be changed at that Time (See Copy of Form in use as Attachment #4). MS. [illegible] will be Responsible For Activity Assessment Review. (J) 6/25/09 * Protective Supervision Plan (Attachment #5) added & Implemented As Required)	
H 050	Tuberculosis-Employees NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis	H 050		

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2811HIC	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C W HOME CARE	1664 DEEP SPRING AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 050	Continued From page 4 infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200.	H 050	H050 A.) All TB Testing and Copies have been Completed and are Noted as Attachments #6 & 7. B.) 6 Mo. File Reviews will Note upcoming Dates for Re-Testing and an Appointment will be Made to have These Tests Re-Done before Expiration Date. The Director will be Responsible for Reviewing These Files for Tests C.) 6/15/09	

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2811HIC	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C W HOME CARE	1664 DEEP SPRING AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 050	Continued From page 5 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) This Regulation is not met as evidenced by: Based on record review and interview on 05/29/09, the facility failed to ensure that one (1) caregiver and the Administrator (Employees #1 and #2) complied with NAC 441A.375 regarding	H 050	H050 A.) Employee TB Tests Are Completed AND Attached As Attachments #'s 8 & 9. B.) All Employee Files will be Reviewed ea. 6 Months AND TB Tests will be Scheduled AT Least 30 Days before they Are Due. The Director will be Responsible For Monitoring. C.) 6/15/09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2811HIC	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C W HOME CARE	1664 DEEP SPRING AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 050	Continued From page 6 tuberculosis testing (Employee #1, and #2). Findings include: There was no available files to review for Employee #1 or #2. During the interview, Employee #1 stated "I haven't had a TB test in a few years".	H 050		
H 055	Tuberculosis-Residents NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment; documentation. (NRS 441A.120) 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility. 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a cold, flu or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or	H 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2811HIC	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C W HOME CARE	1664 DEEP SPRING AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 055	Continued From page 7 (7) Has been in close contact with a person who has active tuberculosis. (b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is sooner. (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. A person with a documented history of a positive tuberculosis screening test is exempt from skin testing and routine annual chest radiographs, but the staff of the facility or home shall ensure that the person is evaluated at least	H 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2811HIC	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C W HOME CARE	1664 DEEP SPRING AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 055	Continued From page 8 annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis. 5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFIB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for	H 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2811HIC	A. BUILDING _____ B. WING _____	05/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C W HOME CARE	1664 DEEP SPRING AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 055	Continued From page 9 the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person ' s medical record. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) This Regulation is not met as evidenced by: Based on record review on 05/29/09, the facility failed to ensure that 2 of 2 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #1 and #2). Findings include: The files of Residents #1 and #2 failed to contain a TB 2-step screening.	H 055		